# MEDICAL ELIGIBILITY DETERMINATION



## Background Information

Assessment Start Date: ☐☐–☐☐–☐☐☐☐ (Month – Day – Year)

Provider-Assessor # ☐☐☐☐☐☐☐☐–☐☐☐

Name of Person Coordinating Assessment _____ Title_____

Agency/Organization _____Phone Number_____

## SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

**1. APPLICANT NAME**
First:_____ (MI) _____
Last:_____

**2. ADDRESS**
Street_____
City/Town_____ Cnty_____ State_____
Zip _____Phone (___)_____

**3. SOCIAL SECURITY NO.** ☐☐☐–☐☐–☐☐☐☐

**4. MAINECARE NO.** *(if applicable)* ☐☐☐☐☐☐☐☐☐

**5. MEDICARE NO.** ☐☐☐☐☐☐☐☐☐☐☐

**6A. ASSESSMENT TRIGGER**
1. Service Need
2. Reassessment due
3. Significant Medical Change
4. Financial Change
☐

**6B. PROGRAM ASSESSMENT REQUESTED** *(Choose only one.)* ☐

1 Long Term Care Advisory
2 Adult Day Care Program
3 BEAS Home Maker
4 MaineCare Day Health
5 Consumer Directed PCA
6 Home Based Care
7 Phys. Dis. HCB
8 Elderly HCB
9 Adults w/ Disability HCB
10. PDN-Level I, II, III
11. Adult Family Care Home
12. Level V - Extended PDN
13. NF Assessment
14. 20-day Medicare/MaineCare
15. Medicare to MaineCare
16. 20-day copay to NF MaineCare
17. 30-day Community MaineCare NF
18. Advisory to MaineCare Update
19. Adv. Medicare to Private Pay NF
20. Continuing Stay Review
21. Extraordinary Circumstances to NF
22. Katie Beckett
23. NF PDN - Level IV
24. Congregate Housing
25. TBI
26. MaineCare Home Health
27. PDN Medication - Level VI
28. PDN Venipuncture Only - Level VII
29. Consumer Directed HBC

**7. GENDER** ☐
1. Male 2. Female

**8. RACE/ ETHNICITY** *(Optional)* ☐
1. American Indian/Alaskan
2. Asian/Pacific
3. Black
4. Hispanic
5. White
6. Other

**9. BIRTH DATE** ☐☐–☐☐–☐☐☐☐ (Month – Day – Year)

**10A. MARITAL STATUS** ☐
1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

**10B. CITIZENSHIP** ☐
1. U.S. Citizen 2. Legal alien 3. Other

**11. PRIMARY LANGUAGE** ☐
0. English
1. French
2. Spanish
3. Other_____

**12. CURRENT INCOME SOURCE FOR APPLICANT & HOUSEHOLD** *(Check all that apply.)*

| | App. | Hshld. |
|---|---|---|
| a/b. Social Security | a | b |
| c/d. Private Pension | c | d |
| e/f. VA Benefits | e | f |
| g/h. SSI | g | h |
| i/j. Other | i | j |
| k/l. Assets >$2000.00 | k | l |

**13. CURRENT OR POTENTIAL PAYMENT SOURCE** *(Code a response in each box.)*
0. Not eligible
1. Eligible
2. Eligibility pending (application filed)
3. Eligibility anticipated (application not yet filed)
4. Unknown

a. Community MaineCare (Routine home health, PDN) a
b. HCB - Elderly, AD b
c. HCB - Phys. Dis. c
d. NF MaineCare d
e. Medicare Part A e
f. Medicare Part B f
g. Champus g
h. VA h
i. Title XX i
j. Other j

**14. LOCATION AT TIME OF ASSESSMENT & USUAL RESIDENCE**
1. Hospital
2. Home/apartment
3. Congregate housing
4. Residential Care Facility
5. Nursing Home
6. Assisted Living Unit
7. Adult Family Care Home
8. Adult Foster Home
9. Other _____

A. Location at time of assessment ☐
B. Usual place of residence ☐

**15. USUAL LIVING ARRANGEMENT**
Lives with: *(Check all that apply.)*
a. Alone a
b. With spouse b
c. With children c
d. With other residents d
e. With parents e
f. With friend f
g. With sibling g
h. Sig. other h
i. Other _____ i

**16. NO. IN HOUSEHOLD** *(Incl. applicant)*
*Other than in institution/residential care facilities* ☐☐

**17. RESPONSIBILITY/LEGAL GUARDIAN** *(For only those items with supporting documentation)*
*(Check all that apply.)*
a. Legal guardian a
b. Other legal oversight b
c. Durable power attorney/ health care proxy c
d. Family member responsible d
e. Applicant responsible e
f. Other f
g. Unknown g

**18. ADVANCED DIRECTIVES** *(For only those items with supporting documentation)*
*(Check all that apply.)*
a. Living will a
b. Do not resuscitate b
c. Do not hospitalize c
d. Organ donation d
e. Autopsy request e
f. Feeding restrictions f
g. Medication restrictions g
h. Other _____ h
i. NONE OF ABOVE i

**19. CONTACTS**

A. Name _____
Address _____
_____
Relationship _____
Telephone _____ Legal Guardian ☐ Yes ☐ No

B. Name _____
Address _____
_____
Relationship _____
Telephone _____ Legal Guardian ☐ Yes ☐ No

**20. REFERRING PHYSICIAN** _____
Address_____
_____
Telephone_____

**CONTINUING PHYSICIAN** _____
Address _____
_____
Telephone _____

Homebound 0 - No 1 - Yes ☐